MISSISSIPPI

CERTIFICATES OF INSURANCE

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CERTIFICATES OF INSURANCE INCLUDED IN THIS PDF

	PAGE #S	GROUP CERTIFICATES OF INSURANCE
	02-29	Group Benefits Fixed Indemnity Insurance underwritten by: United States Fire Insurance Company
	30-47	Critical Illness Rider underwritten by: United States Fire Insurance Company

READ CAREFULLY FOR ALL LIMITATIONS, EXCLUSIONS, AGE LIMITS, DEFINITIONS AND SCHEDULE OF BENEFITS.
CALL **866-438-4274** WITH ANY QUESTIONS.

United States Fire Insurance Company

Wilmington, Delaware
Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

GROUP BENEFITS FIXED INDEMNITY
CERTIFICATE OF INSURANCE

POLICYHOLDER:	United Business Association
POLICY NUMBER:	US2252661
POLICY EFFECTIVE DATE:	11/1/2025
POLICY EXPIRATION DATE:	Until Cancelled

This Certificate is evidence of the Covered Person's insurance under the Policy that We have issued to the Policyholder named above. The provisions of the Policy are summarized in this Certificate. This Certificate replaces any other Certificate We may have previously provided to the Covered Person under the Policy.

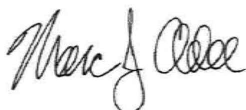
The Policy is issued in the state of Florida.
The Policy is governed by the laws of the state where it was delivered.

The Policy is a legal contract between the Policyholder and United States Fire Insurance Company (herein referenced as the Company). The Policy alone is the only contract under which payment will be made. The Policy may be inspected at the office of the Policyholder.

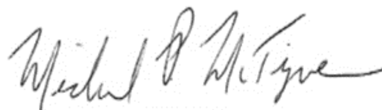
THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS INSURANCE EVIDENCED BY THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS CERTIFICATE DOES NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE AND DOES NOT SATISFY THE REQUIREMENT OF MINIMUM ESSENTIAL COVERAGE UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, AS AMENDED, AND/OR ANY RELATED LEGISLATION.
PLEASE READ THIS CERTIFICATE CAREFULLY.

THE POLICY IS OPTIONALLY RENEWABLE.
Non-Participating Insurance

Signed for **United States Fire Insurance Company** by:



Marc J. Adee
Chairman and CEO



Michael P. McTigue
Secretary

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SCHEDULE OF BENEFITS

POLICYHOLDER:	United Business Association
POLICY NUMBER:	US2252661
POLICY EFFECTIVE DATE:	11/1/2025
CERTIFICATE EFFECTIVE DATE:	The Requested Effective Date shown on the Enrollment Form
CERTIFICATE PERIOD:	Begins on the Certificate Effective Date and continues for each subsequent 12-month period until termination

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CLASSES OF ELIGIBLE PERSONS:

A person may be covered only under one Class of Eligible Persons even though the person may be eligible under more than one class. Also, a person may not be covered as a Dependent and an Insured Person at the same time.

Class I Members of the Policyholder age 18-65.
Class II Spouse /Civil Union Partner/Domestic Partner of Class I when such Spouse /Civil Union Partner Domestic Partner is under age 65.
Class III Dependent Child(ren) of Class I and Class II.

LIMITED FIXED INDEMNITY BENEFITS

THE FOLLOWING SHALL APPLY TO EACH COVERED PERSON:

LIFETIME MAXIMUM BENEFIT: for Classes I, II, and III $1,000,000 per Covered Person

BENEFIT WAITING PERIOD for Sickness for the following Benefits: for Classes I, II, and III 30 days per Covered Person

Hospital Confinement Benefit
Inpatient Surgery Benefit
Inpatient Surgery Anesthesia Benefit
Outpatient Surgery Benefit
Outpatient Surgery Anesthesia Benefit
Diagnostic Exam-Outpatient Only Benefit
X-Ray -Outpatient Only Benefit
Lab Test -Outpatient Only Benefit

COVERED BENEFIT FOR EACH COVERED PERSON All Classes:	BENEFIT AMOUNT
Hospital Admission Benefit	$2,000 for the first day of Hospital Confinement up to 1 Occurrence per Certificate Period Benefit is payable in addition to Hospital Confinement Benefit
Hospital Confinement Benefit	$4,000 per day for days 1-30 for a Hospital Confinement occurring in a Certificate Period and subject to a Maximum Benefit of $1,000,000 per Certificate Period

Benefit	Amount
Emergency Room Visits Benefit for Sickness and Injury	$300 per day up to a Maximum Benefit of 2 days per Certificate Period for Injury and Sickness combined
Inpatient Surgery Benefit	$5,000 per day up to a Maximum Benefit of 1 day per Certificate Period
Inpatient Surgery Anesthesia Benefit	$1,250 per day up to a Maximum Benefit of 1 day per Certificate Period
Outpatient Surgery Benefit	$2,500 per day up to a Maximum Benefit of 1 day per Certificate Period
Outpatient Surgery Anesthesia Benefit	$350 per day up to a Maximum Benefit of 1 day per Certificate Period
Wellness Office Visits Benefit	$25 per day up to a Maximum Benefit of 4 days per Certificate Period for Wellness visits to a Medical Professional
Wellness Tests Benefit	$300 per day up to a Maximum Benefit of 3 days per Certificate Period
Ambulance - Air Benefit	$1,500 per day for up to 1 day per Injury or Sickness and up to a Maximum Benefit of 1 day per Certificate Period. Air Ambulance transportation must occur within 1 day after the Covered Accident or Sickness occurs.
Ambulance - Ground or Water Benefit	$150 per day for up to 2 days per Injury or Sickness and up to a Maximum Benefit of 2 days per Certificate Period. Ground or Water Ambulance transportation must occur within 1 day after the Covered Accident or Sickness occurs.
Prescription Drug Benefit	$50 per day up to a Maximum Benefit of 15 days per Certificate Period
Diagnostic Exam -Outpatient Only Benefit	$600 per day for up to 3 days per Injury or Sickness and up to a Maximum Benefit of 3 days per Certificate Period. The Diagnostic Exam must occur within 90 days after the Covered Accident or Sickness occurs.
X-Ray -Outpatient Only Benefit	$250 per day for up to 1 day per Injury or Sickness and up to a Maximum Benefit of 1 day per Certificate Period. The X-Ray must occur within 90 days after the Covered Accident or Sickness occurs.
Lab Test -Outpatient Only Benefit	$350 per day for up to 2 days per Injury or Sickness and up to a Maximum Benefit of 2 days per Certificate Period. The Lab Test must occur within 90 days after the Covered Accident or Sickness occurs.

Therapy Services Visit Benefit	$75 per day for up to 12 days per Injury or Sickness and up to a Maximum Benefit of 12 days per Certificate Period. Therapy Services must begin within 90 days after the Covered Accident or Sickness occurs and be rendered within 180 days after the Covered Accident or Sickness occurs.

DEFINITIONS

Please note certain words used in this document have specific meanings. Additional terms may be defined within the provision to which they apply.

The capitalized terms used herein are defined as follows:

Accident means a sudden, unforeseeable event which:
(1) Causes Injury to one or more Covered Persons; and
(2) Occurs while coverage is in effect for the Covered Person.

Certificate Holder means the Insured Person to whom an insurance Certificate has been issued evidencing coverage under the Policy.

Certificate Period means the period of time specified in the Schedule of Benefits.

Child or Children means the Insured Person's natural child, adopted child (or child placed in the Insured Person's home for purposes of adoption), foster child, stepchild, or other child for whom the Insured Person has legal guardianship (proof will be required).

Civil Union Partner means the parties to a civil union who are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded to spouses. Throughout the Policy, a party to a civil union shall be included in any definition or use of the terms such as Spouse, family, dependent, next of kin, and other terms descriptive of spousal relationships. This includes the terms 'marriage' or 'married' or variations thereon. The term Spouse or Dependent includes civil union couples whenever used.

Company means United States Fire Insurance Company. Also hereinafter referred to as We, Us and Our.

Complications of Pregnancy means a condition which:

- When pregnancy is not terminated, requires medical treatment and whose diagnosis is distinct from pregnancy but is adversely affected by or are caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; and (i) other similar medical and surgical conditions of comparable severity related to pregnancy.
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will not include:

- False labor;
- Occasional spotting;
- Medical Professional prescribed rest during the period of pregnancy;
- Morning sickness;
- Preeclampsia; and
- Similar conditions associated with the management of a difficult pregnancy, but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a complication of pregnancy if the cesarean section is non-elective. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the Child or mother.

Covered Accident means an Accident that occurs while coverage is in force for a Covered Person and results in a Covered Loss for which benefits are payable.

Covered Loss or Covered Losses means an Injury or Sickness covered under the Policy and indicated on the Schedule of Benefits.

Covered Person means an Insured Person and Dependent eligible for coverage as identified in the Enrollment/Application, for whom proper premium payment has been made when due, and who is therefore insured under the Policy.

Dependent means an Insured Person's:
1) lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner;
2) unmarried Children under age 26.

The age limitations will not apply to an Insured Person's unmarried Child who is incapable of self-sustaining employment by reason of mental or physical incapacity. Proof of such incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.

Domestic Partner means an opposite or same sex partner who, for at least 6 consecutive months, has resided with the Insured Person and shared financial assets/obligations with the Insured Person. Both the Insured Person and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Insured Person nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

Emergency Room means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an Outpatient basis. An Emergency Room is not a clinic, Medical Professional's or Specialist's office.

Experimental or Investigational means a service for which one or more of the following is true:
1. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. We will determine if this item 1. is true based on:
    A. Published reports in authoritative medical literature; and
    B. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health and the Food and Drug Administration (FDA).
2. In the case of a drug, a device or other supply that is subject to FDA approval:
    A. It does not have FDA approval; or
    B. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:
        1) Included in substantially accepted peer-reviewed medical literature such as: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        2) Included in a Prescription Drug reference compendium; or
        3) In addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.

3. The Medical Professional's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to the board's approval.
4. Research protocols indicate that the service or supply is Experimental or Investigational. This item 4 applies for protocols used by the Covered Person's Medical Professional as well as for protocols used by other Medical Professionals studying substantially the same service or supply.

Gender Transition Procedures means any of the following medical or surgical services performed for the purpose of assisting an individual with a gender transition:
1. Prescribing or administering puberty-blocking drugs;
2. Prescribing or administering cross-sex hormones; or
3. Performing gender reassignment surgeries.

Gender Transition Procedures do not include services to persons born with a medically verifiable disorder of sex development, including a person with external sex characteristics that are irresolvably ambiguous, such as those born with forty-six (46) XX chromosomes with virilization, forty-six (46) XY chromosomes with undervirilization, or having both ovarian and testicular tissue.

Hospital means an institution licensed, accredited or certified by the State that:
1) Operates as a Hospital pursuant to law for the care, treatment and providing Inpatient services for sick or injured persons;
2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call;
4) Has a staff of one or more licensed Medical Professionals available at all times;
5) Provides organized facilities for diagnosis, treatment and surgery, either
   a) on its premises; or
   b) in facilities available to it, on a pre-arranged basis;

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.
We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:
1) the Joint Commission of Accreditation of Hospitals; or
2) the American Osteopathic Association; or
3) the Commission on the Accreditation of Rehabilitative Facilities.

In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Covered Benefit under the Policy.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.

Hospital Stay or Hospital Confinement means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a charge is made by the Hospital.

Immediate Family Member means a Covered Person's Spouse, Domestic Partner, Civil Union Partner, parent, Child(ren) (includes legally adopted or step child(ren), brother, sister, grandchild(ren), or in-laws.

Injury means bodily Injury caused by the direct result of an Accident occurring after the effective date of a Covered Person's coverage under the Policy, while the Policy is in force as to the person whose Injury is the basis of the claim which results, directly and independently of disease, bodily infirmity and all other causes, in a Covered Loss. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single Injury.

Inpatient means a Covered Person who is charged for at least one (1) day's room and board from a Hospital; or more than 23 hours in an observation unit.

Insured Person means a person in a Class of Eligible Persons described in the Schedule of Benefits who has a direct relationship with the Policyholder, who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person under the Policy. A Dependent covered under the Policy is not an Insured Person.

Laboratory Tests means the procedures that are intended to detect, identify, or quantify one or more significant substances, evaluate organ functions, or establish the nature of a condition or disease.

Medical Emergency means a Sickness or Injury for which the Covered Person seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:

- His life or health would be in serious jeopardy, or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;
- Serious disfigurement of the Covered Person;
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

Treatment for Medical Emergency will be paid only for Sickness or Injury which fulfills the above conditions.

Medically Necessary or Medical Necessity means a treatment, drug, device, service, procedure or supply that is:

1) Required, necessary and appropriate for the diagnosis or treatment of a Sickness or Injury;
2) Prescribed or ordered by a Medical Professional or furnished by a Hospital;
3) Performed in the least costly setting required by the condition;
4) Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

In order for a Hospital confinement to be Medically Necessary, the diagnosis or treatment of symptoms or a condition must not be able to be safely provided on an Outpatient basis.

The fact that a Medical Professional may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Policy.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental or Investigational or for research purposes;
- Is provided for education purposes or the convenience of the Covered Person, the Covered Person's family, Medical Professional , Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the person's condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- It can be safely provided to the patient on a more cost- effective basis, such as by Outpatient care, by a different Medical Professional, or pursuant to a more conservative form of treatment.

Medical Professional(s) means a person who is a Physician or who is not a Physician but is appropriately licensed to provide some medical care and treatment, including a chiropractor, dentist, optometrist, nurse practitioner

(NP/APRN), physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). The Medical Professional must be acting within the scope of their license, relevant board certifications, and qualifications. If required by law, the Medical Professional must be under the supervision of a Physician. A Medical Professional does not include a Covered Person or Covered Person's Immediate Family Member. This does not include holistic providers.

Mental Illness or Nervous Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the medical care or treatment is rendered to a Covered Person.

Nurse means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

Occurrence means all losses or damages that are attributable to directly or indirectly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one Occurrence without regard to the period of time or the area over which such losses occur.

Optionally Renewable means renewal is at the option of United States Fire Insurance Company.

Outpatient means a Covered Person who receives care in a surgical or medical center which has (1) permanent facilities for surgery; (2) organized medical staff of Medical Professionals and Nurses; (3) is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under law, without being admitted.

Physician means a person who is a qualified practitioner of medicine. As such, they must be acting within the scope of their license under the laws in the state in which they practice and providing only those medical services which are within the scope of their license or certificate. It does not include a Covered Person or Covered Person's Immediate Family Member.

Policyholder means the entity shown as the Policyholder in the Schedule of Benefits.

Pre-Existing Condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period before the Covered Person's Effective Date.

Prescription Drug means any medication or medicinal substance which has been approved by the U.S. Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a Prescription Order (a legend drug).

Radiology or Radiology Test(s) means the scientific discipline of medical imaging using ionizing radiation, radionuclides, nuclear magnetic resonance, and ultrasound.

Sickness means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person receives medical treatment while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

Skilled Nursing Care Facility means a facility that provides skilled nursing care 24 hours a day, seven days a week, under the supervision of a Medical Professional, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A Skilled Nursing Care Facility provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.

Spouse means lawful spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner.

Substance Abuse means the use of any drug or substance(s) for non-therapeutic purposes; or use of medication for purposes other than those for which it is prescribed.

Surgery or **Surgical Procedure** means the manual and/or operative procedures for correction of deformities and defects, repair of injuries, diagnosis and cure of diseases, relief of suffering and prolongation of life.

Urgent Care Facility means a free-standing facility, which is engaged primarily in providing minor emergency and episodic medical care on an immediate basis without appointment, other than a Hospital (including any Outpatient department of a Hospital), Emergency Room, or Medical Professional's office/clinic. It must be licensed as an Urgent Care Facility, if required by law.

We, Our, Us means United States Fire Insurance Company underwriting this insurance or its authorized agent.

X-Ray means a form of electromagnetic radiation that passes through structures within the body and results in images of the structures. This definition does not include any Diagnostic Exam or Lab Test.

ELIGIBILITY FOR INSURANCE

Persons eligible to be insured under the Policy are those persons described as being in a Class of Eligible Persons on the Schedule of Benefits. This includes anyone who may become eligible while the Policy is in force.

We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

An Insured Person's Dependent(s), as defined, are eligible on the latest of the date:
1) the Insured Person is eligible, if the Insured Person has Dependents on that date; or
2) the date the person becomes a Dependent.

If the Insured Person is in a Class of Eligible Persons and is also eligible as a Dependent, they may be covered only once under the Policy. In no event will a Dependent be eligible if the Insured Person is not eligible.

EFFECTIVE DATE OF INSURANCE

Policy Effective Date: The Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder.

Covered Person's Effective Date:
An Eligible Person will become insured under the Policy, provided proper premium payment is made, on the latest of:
(1) The Effective Date of their Certificate; or
(2) The day they become eligible, according to the referenced date shown in the Enrollment Form.

Newborn Children Coverage: We will provide coverage for a newborn Child from the moment of birth. The Insured Person must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate at the expiration of the initial 31 day period.

Newborn Adopted Children Coverage: In the case of adoption of a newborn Child, coverage will be on the same basis as a newborn Child if a written agreement to adopt such Child has been entered into by the Insured Person prior to the birth of the Child, whether or not such agreement is enforceable. The Insured Person must give Us notice within 31 days of the birth of the adopted Child. If notice is not given within 31 days, coverage for the newborn adopted Child will terminate at the expiration of the initial 31 day period.

Newborn Child Exception: This section does not apply to a newborn Child if the Child is born to a Covered Person while insured as a Dependent Child under the Policy. Benefits for newborn Children apply only to a Child born to an Insured Person or their Spouse, Domestic Partner or Civil Union Partner.

Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of placement in the Insured Person's home. A notice of placement for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate at the expiration of the initial 31 day period.

Court Ordered Custody: A Child placed in court-ordered custody, including a foster Child, will be covered on the same basis as an adopted Child.

TERMINATION DATE OF INSURANCE:

Policy Termination Date

Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Policy terminates automatically on the earlier of:

1) The Policy Expiration Date shown in the Policy; or
2) The premium due date if premiums are not paid when due, subject to any Grace Period.

Failure by the Policyholder to pay all required premiums due by the last day of the Grace Period shall be deemed notice by the Policyholder to the Company to terminate the Policy at the end of the Grace Period. The Policyholder shall be liable to the Company for the payment of a pro rata premium for the time the Policy was in force during the Grace Period.

The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 60 days prior to such date.

The Policyholder and the Company may terminate the Policy at any time by written mutual consent.

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.

Insured Person's Termination Date

Insurance for an Insured Person will end on the earliest of:

1) The date the Insured Person is no longer in an Eligible Class.
2) The date the Insured Person reports for full-time active duty in any Armed Forces We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
    a. The date the premium is fully earned; or
    b. The Expiration Date of their Certificate.

    This does not include Reserve or National Guard duty for training;
3) The end of the period for which the last premium contribution is made, subject to any Grace Period; or
4) The date the Policy is terminated; or
5) The date the Insured Person requests, in writing, that their coverage be terminated; or
6) The date the membership ends.

Dependent's Termination Date

A Dependent's coverage under the Policy ends on the earliest of:

1. The date the Policy terminates; or
2. The date the Insured Person's coverage ends; or
3. The date the Dependent is no longer a Dependent; or
4. The date the Covered Person reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
    a. The date the premium is fully earned; or
    b. The Expiration Date of their Certificate.

    This does not include Reserve or National Guard duty for training;
5. The last day of the period for which premiums have been paid, subject to any Grace Period.

PREMIUM PROVISIONS

Premiums:
The Company provides insurance in return for premium payments. The premium shown in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium due dates are the first of every month unless otherwise stated in the Policy. Premium payment made in advance or for more than a one-month period will not affect any provisions of the Policy with regard to change. Failure by the Policyholder to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate coverage at the end of the Grace Period. The Policyholder shall be liable to the Company for the payment of a pro rata premium for the time the Policy was in force during the Grace Period.

The Company has the right to rely upon the accuracy of the Policyholder's calculations and to require the Policyholder to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Policyholder will pay the additional premium or apply the premium credit at the next premium due date.

Upon the payment of a claim under the Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Grace Period:
This Certificate has a 31 day Grace Period for the payment of each premium due after the first premium due date. Coverage will stay in force during this Grace Period. It will terminate at the end of the Grace Period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

Changes in Premium Rate:
The Company may change the premium rates from time to time with at least 75 days advanced written or authorized electronic notice. Notice will be sent to the Policyholder's most recent address in Our records.

No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more than once in a 12-month period. However, the Company reserves the right to change rates at any time if any of the following events occur:

1) A change in the terms of the Policy.
2) A subsidiary, division, affiliated organization, or eligible class is added or deleted to the Policy.
3) A change in any federal or state law or regulation affecting the Policy and Our benefit obligation.
4) A change in the factors bearing on the risk assumed.
5) A misrepresentation in the information relied on in establishing the rate for the Policy.
6) A change in the experience rating.

Reinstatement
If any renewal premium be not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. However, if We or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified the Policyholder in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after such date. In all other respects the Policyholder and Us shall have the same rights

thereunder as the parties had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Certificate. Benefits are only provided while the Covered Person's coverage is effective. These benefits are subject to the Maximum Benefit amounts and other terms or limits, such as number of sessions, shown below and in the Schedule of Benefits. Benefits will not duplicate any other benefits payable under this Certificate or any coverage(s) attached to this Certificate unless otherwise stated below or in the Schedule of Benefits.

Hospital Admission Benefit

We will pay the Hospital Admission Benefit shown in the Schedule of Benefits if a Covered Person is Hospital Confined and all of the following conditions are met:

1. the Hospital Stay is Medically Necessary and the direct result, from no other causes, of Injuries or illness sustained in a Covered Accident or from a Sickness; and
2. the Hospital Stay is the first day of Hospital Confinement for the Covered Person during the Certificate Period.

This benefit will be paid in addition to the Hospital Confinement Benefit.

Hospital Confinement Benefit

We will pay the Hospital Confinement Benefit shown in the Schedule of Benefits if a Covered Person is Hospital Confined as an Inpatient and all of the following conditions are met:

1. the Hospital Stay is Medically Necessary and the direct result, from no other causes, of Injuries or illness sustained in a Covered Accident or from a Sickness; and
2. Hospital Confinement is at the direction and under the care of a Medical Professional ; and
3. while the Covered Person's coverage is in effect.

Benefit payments will end on the first of the following dates:

1. the date the Hospital stay ends; or
2. the date the Covered Person dies; or
3. the date the Maximum Benefit for this benefit is payable; or
4. the date insurance under the Policy ends for the Covered Person.

Emergency Room Visits Benefit for Sickness and Injury

We will pay the benefit shown in the Schedule of Benefits for Emergency Room visits if a Covered Person requires Hospital Emergency Room treatment for a Medical Emergency as the result of an Injury due to a Covered Accident or a Sickness.

Inpatient Surgery Benefit

We will pay the Inpatient Surgery Benefit shown in the Schedule of Benefits if a Covered Person is ordered by a Medical Professional to undergo Medically Necessary Surgery as the result of a Covered Accident or Sickness.

Inpatient Surgery must be performed in the operating room of a Hospital.

Inpatient Surgery Anesthesia Benefit

We will pay the Inpatient Surgery Anesthesia Benefit shown in the Schedule of Benefits if a Covered Person is administered anesthesia on an Inpatient basis for a Medically Necessary Surgery as the result of a Covered Accident or Sickness.

Outpatient Surgery Benefit

We will pay the Outpatient Surgery Benefit shown in the Schedule of Benefits if a Covered Person is ordered by a Medical Professional to undergo Medically Necessary Surgery as the result of a Covered Injury or Sickness.

Outpatient Surgery must be performed in the Outpatient department of a Hospital or an Ambulatory Surgical Center.

Ambulatory Surgical Center means a free standing facility providing ambulatory surgical or medical treatment other than a Hospital, clinic, Medical Professional's or Specialist's office. It must be qualified to provide the treatment under the standards set by the state in which it is located.

This benefit does not include Surgery performed in a surgical suite, Medical Professional's or Specialist's office.

Outpatient Surgery Anesthesia Benefit

We will pay the Outpatient Surgery Anesthesia Benefit shown in the Schedule of Benefits if a Covered Person is administered anesthesia on an Outpatient basis for a Medically Necessary Surgery as the result of a Covered Accident or Sickness.

Wellness Office Visits Benefit

We will pay the benefit shown in the Schedule of Benefits for Wellness Office Visits if a Covered Person visits a Medical Professional. These services will be covered only to the extent that they are provided by, or under the supervision of, a Medical Professional during the course of one visit. Services include visits to receive immunizations as provided by department of health regulation.

Wellness Tests Benefit

We will pay the benefit shown in the Schedule of Benefits for Wellness Tests if the tests are ordered by a Medical Professional and performed by an appropriately licensed technician. This includes pap smear test, Prostate Cancer Screening, mammography. This does not include Laboratory Tests or Radiology Tests.

Prostate Cancer Screening means a PSA test and/or Digital Rectal Exam.

Ambulance - Air Benefit

We will pay the Ambulance - Air Benefit shown in the Schedule of Benefits, subject to the following conditions, if the Covered Person requires Air Ambulance services due to a Covered Accident Sickness.

The Air Ambulance services provided must be for transportation from the scene of the Covered Accident to the nearest Hospital that is able to provide appropriate care, or in the event of a Sickness, the Medically Necessary transportation to a Hospital. This benefit is payable for up to 1 day per Injury Sickness and up to a Maximum

Benefit of 1 day per Certificate Period for each Covered Person. Air Ambulance transportation must occur within 1 day after the Covered Accident or Sickness occurs.

If more than one form of ambulance transport occurs on the same day, only the highest ambulance benefit is payable.

Air Ambulance means air transportation provided by a licensed professional ambulance company in a vehicle designed, equipped and used only to transport the sick or injured to the closest local facility that can provide the medical care appropriate to the condition. If there is no such local facility available, coverage is for trips to the closest facility outside the local area.

Ambulance – Ground or Water Benefit

We will pay the Ambulance – Ground or Water Benefit shown in the Schedule of Benefits, subject to the following conditions, if the Covered Person requires Ground or Water Ambulance services due to a Covered Accident or Sickness.

The Ground or Water Ambulance services provided must be for transportation from the scene of the Covered Accident to the nearest Hospital that is able to provide appropriate care, or in the event of a Sickness, the Medically Necessary transportation to a Hospital. This benefit is payable for up to 2 days per Injury or Sickness and up to a Maximum Benefit of 2 days per Certificate Period for each Covered Person. Ground or Water Ambulance transportation must occur within 1 day after the Covered Accident or Sickness occurs.

If more than one form of ambulance transport occurs on the same day, only the highest ambulance benefit is payable.

Ground Ambulance means transportation provided by a licensed professional ambulance company in a vehicle designed, equipped and used only to transport the sick or injured to a Hospital. Surface trips must be to the closest local facility that can provide the medical care appropriate to the condition. If there is no such local facility available, coverage is for trips to the closest facility outside the local area.

Water Ambulance means transportation provided by a licensed professional ambulance company in a publicly or privately owned vessel that is specifically designed, constructed or modified and equipped, and intended to be used for and is maintained or operated for the transportation upon the waterways to transport the sick or injured to the closest local facility that can provide the medical care appropriate to the condition. If there is no such local facility available, coverage is for trips to the closest facility outside the local area.

Prescription Drug Benefit
We will pay the benefit shown in the Schedule of Benefits for Medically Necessary Prescription Drugs that are purchased by a Covered Person for treatment within 30 days of a Covered Accident or Sickness.

The following are not considered to be Medically Necessary Prescription Drugs and these medications are specifically not covered under this Benefit:

1. Over-the-counter medications, supplies or products;
2. Medications or other agents to increase or enhance fertility or the likelihood of conception;
3. Medications for the treatment of erectile dysfunction or to assist in or enhance sexual performance;
4. Vitamins and or nutritional supplements;
5. Medications to eliminate or reduce a dependency or an addiction to tobacco including, but not limited to, the cessation or termination of cigarette, cigar, or tobacco smoking or the use of smokeless tobacco, including nicotine products, gums and transdermal patches;

6. Medications for the treatment of hair loss or for the purpose of regrowing lost hair, such as Rogaine, Minoxidil;
7. Immunization agents, biological sera, blood or blood plasma;
8. Medications for the treatment or obesity or diet control;
9. Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use;
10. Homeopathic medications;
11. Any medication purchased outside the United States of America.

Diagnostic Exam -Outpatient Only Benefit

We will pay the Diagnostic Exam -Outpatient Only Benefit amount shown in the Schedule of Benefits for each day that a Covered Person undergoes a Diagnostic Exam on an Outpatient basis for the purpose of diagnosing an Injury or Sickness. The Diagnostic Exam must occur within 90 days after the Covered Accident or Sickness occurs.

This benefit will not be paid for a Diagnostic Exam that occurs on an Inpatient basis.

This benefit is only payable once per day, even if more than one Diagnostic Exam occurs or the Diagnostic Exam is for more than one Injury or Sickness. If more than one Diagnostic Exam or Lab Test or X-Ray occurs on the same day, only the highest applicable benefit is payable.

Diagnostic Exam means any of the following major/advanced tests: angiogram, arteriogram, bone scintigraphy, CT, EEG, EKG, EMG, MRI, PET, SPECT, or thallium stress test. This definition does not include any Lab Test or X-Ray.

X-Ray -Outpatient Only Benefit

We will pay the X-Ray -Outpatient Only Benefit amount shown in the Schedule of Benefits for each day that a Covered Person undergoes an X-Ray on an Outpatient basis for the purpose of diagnosing an Injury or Sickness. The X-Ray must occur within 90 days after the Covered Accident or Sickness occurs.

This benefit will not be paid for an X-Ray that occurs on an Inpatient basis.

This benefit is only payable once per day, even if more than one X-Ray occurs or the X-Ray is for more than one Injury or Sickness. If more than one X-Ray or Diagnostic Exam or Lab Test occurs on the same day, only the highest applicable benefit is payable.

Lab Test -Outpatient Only Benefit

We will pay the Lab Test -Outpatient Only Benefit amount shown in the Schedule of Benefits for each day that a Covered Person undergoes a Lab Test on an Outpatient basis for the purpose of diagnosing an Injury or Sickness. The Lab Test must occur within 90 days after the Covered Accident or Sickness occurs.

This benefit will not be paid for a Lab Test that occurs on an Inpatient basis.

This benefit is only payable once per day, even if more than one Lab Test occurs or the Lab Test is for more than one Injury or Sickness. If more than one Lab Test or X-Ray or Diagnostic Exam occurs on the same day, only the highest applicable benefit is payable.

Lab Test means a laboratory study of human blood, bodily tissues or fluids, such as a blood chemistry or urinalysis. This definition does not include any Diagnostic Exam or X-Ray.

Therapy Services Visit Benefit

We will pay the Therapy Services Visit Benefit amount shown in the Schedule of Benefits for each day that a Covered Person receives Therapy Services from a Therapist in the Therapist's office or clinic as the result of an Injury or Sickness. The Therapy Services must be prescribed by a Medical Professional, or recommended by a Medical Professional for acupuncture or chiropractic care. This benefit is only payable once per day, even if Therapy Services are received for more than one Injury or Sickness. Therapy Services must begin within 90 days after the Covered Accident or Sickness occurs and be rendered within 180 days after the Covered Accident or Sickness occurs.

This benefit will not be paid for any day for which any Hospital Confinement benefit is payable.

Therapist means a person who is appropriately licensed to practice and provide acupuncture, chiropractic care, occupational therapy, physical therapy or speech therapy. Such Therapist must be acting within the scope of their license. A Therapist does not include the Covered Person or the Covered Person's Immediate Family Member.

Therapy Services means acupuncture, chiropractic care, occupational therapy, physical therapy or speech therapy.

GENERAL EXCLUSIONS

The Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following:

1. Suicide, attempted suicide or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. While the Covered Person is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;
4. Active participation in a riot or insurrection;
5. Treatment which arises out of, or in the course of fighting, brawling, assault or battery.
6. Treatment for Mental Illness or Nervous Disorders, except as specifically provided in the Policy.
7. Treatment for Substance Abuse, except as specifically provided in the Policy.
8. Injury or Sickness caused by, contributed to or resulting from the Covered Person being intoxicated or being under the influence of illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Medical Professional.
9. Violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
10. Services or treatment rendered by a Medical Professional or any other person who is employed by the Policyholder; or an Immediate Family Member of the Covered Person.
11. Travel or activity outside the United States, except for treatment of a Medical Emergency.
12. Participation in any motorized race or speed contest.
13. Injury to a Covered Person resulting from that Covered Person's willful violation of the Policyholder's rules or regulations. Willful violation includes, but is not limited to: a) working without protective clothing, helmets, gloves, etc., required by the Policyholder's rules or regulations; or b) participating in any activity that is in violation of the Policyholder's rules or regulations.
14. pregnancy, except Complications of Pregnancy, or childbirth unless conception occurred while coverage was in force under the Policy.
15. Elective Abortion. Elective Abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.
16. Experimental or Investigational drugs, services, supplies or procedure that is Experimental or Investigational at the time the procedure is done.
17. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
18. Treatment or services provided by a private duty nurse, unless provided for in the Policy.
19. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
20. Dental services, except as specifically provided in the Policy.
21. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in the Policy.
22. Treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance, or removal of orthodontic or occlusal appliances or equilibration therapy; or craniomandibular joint dysfunction and associated myofascial pain, except as specifically provided in the Policy.
23. Treatment for blood or blood plasma;
24. Routine vision care, except as specifically provided in the Policy.
25. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license;
26. Travel in or upon, alighting to or from, or working on or around any motorcycle or recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle; four-wheeled all terrain vehicle (ATV);

jet ski; ski cycle; snow mobile; or riding in a rodeo according to the Policy provisions; or any off-road motorized vehicle not requiring licensing as a motor vehicle;

27. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
    i. While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
    ii. While being used for any test or experimental purpose; or
    iii. While piloting, operating, learning to operate or serving as a member of the crew thereof; or
    iv. While traveling in any such aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of His household; or
    v. A space craft or any craft designed for navigation above or beyond the earth's atmosphere;

    Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business or pleasure purposes.
28. Rest cures or custodial care;
29. Prescription Drugs unless specifically provided for under the Policy.
30. Elective or cosmetic Surgery, except for reconstructive Surgery on a diseased or injured part of the body;
31. Physiotherapy services.
32. Services related to sterilization, reversal of a vasectomy or tubal ligation; in vitro fertilization and diagnostic treatment of infertility or other problems related to the inability to conceive a child, unless such infertility is a result of a covered Injury or Sickness.
33. No benefits will be paid for an Injury incurred while working for pay or profit.
34. Hang-gliding, parachuting, bungee-cord jumping or flight involving, including boarding or alighting from, an ultralight aircraft.
35. Providing or reimbursing Gender Transition Procedures for people under age 18.

Pre-existing Conditions Limitation

There is no coverage for a Pre-Existing Condition for a period of the first 6 months after the Covered Person's Effective Date of coverage. This Pre-Existing Condition Limitation only applies to the following Benefits:

Hospital Admission Benefit
Hospital Confinement Benefit
Inpatient Surgery Benefit
Inpatient Surgery Anesthesia Benefit
Outpatient Surgery Benefit
Outpatient Surgery Anesthesia Benefit

This Pre-Existing Condition Limitation does not apply to a newborn or newly adopted Child or Child under petition for adoption under the age of 18 if the Child is enrolled for coverage within 90 Days from the date of birth, or the 60 Day period beginning on the date of adoption or filing of a petitioner for adoption.

CLAIM PROVISIONS

NOTICE OF CLAIM:
Written notice of claim must be given to Us within 30 days after a Covered Loss occurs or begins or as soon as reasonably possible. Notice can be given at Our administrative office as shown on the cover page or to Our authorized licensed agent. Notice should include the Policyholder's name and the Policy Number and a Covered Person's name and address.

If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:
1) it can be shown that it was not possible within reason to submit notice within the 30 day period; and
2) it is further shown that notice was given as soon as possible.

CLAIM FORMS:
We, upon receipt of a written notice of claim, will furnish to the Covered Person such forms as are usually furnished by Us for filing proofs of loss. If forms are not furnished within 15 days after the giving of such notice, the Covered Person shall be deemed to have complied with the requirements as to proof of loss upon submitting, within the time specified for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOF OF LOSS:
Written proof of loss must be furnished to Us in the case of a claim for Covered Loss for which the Policy provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to us at intervals required by Us.

In case of claim for any other Covered Loss, proof must be furnished within 90 days after the date of such loss.

If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:
1) it can be shown that it was not possible within reason to submit notice within the 90 day period; and
2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS:
All benefits payable under the Policy for any loss, other than loss for which the Policy provides any periodic payment, will be paid within 25 days after receipt of due written proof of such loss in the form of a Clean Claim where claims are submitted electronically, and will be paid within 35 days after receipt of due written proof of such loss in the form of a Clean Claim where claims are submitted in paper format. Benefits due under the Policy and claims are overdue if not paid within 25 days or 35 days, whichever is applicable, after We receive a Clean Claim containing necessary medical information and other information essential for Us to administer Pre-existing Condition and Subrogation provisions.

A "Clean Claim" means a claim received by Us for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the Covered Person in order to be processed and paid by Us. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A Clean Claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to Us, do not change the Clean Claim status.

Clean Claim does not include any of the following:

(a) A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within 30 days of the original claim;
(b) Claims which are submitted fraudulently or that are based upon material misrepresentations;
(c) Claims that require information essential for Us to administer Pre-existing Condition or Subrogation provisions; or
(d) Claims submitted by a provider more than 30 days after the date of service; if the provider does not submit the claim on behalf of the Covered Person, then a claim is not clean when submitted more than 30 days after the date of billing by the provider to the Covered Person.

Not later than 25 days after the date We actually receive an electronic claim, We shall pay the appropriate benefit in full or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than 35 days after the date We actually receive a paper claim, We shall pay the appropriate benefit in full or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by Us shall be paid within 20 days after receipt.

For purposes of this provision, the term "pay" means that We shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or the Covered Person.

Subject to due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid within 30 days after receipt of due written proof.

If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed above, We shall pay the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person) interest on accrued benefits at the rate of 3% per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than $1.00, such amount shall be credited to the account of the person or entity to whom such amount is owed.

In the event We fail to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue as provided above and any other damages as may be allowable by law. If it is determined in such action that We acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, the person entitled to such benefits (health care provider or Covered Person) shall be entitled to recover damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

Upon request, We shall provide to the Covered Person or the provider submitting a claim a written list of the information required and the documentation required for Us to deem a claim to be clean, and We shall then be bound to such list.

PAYMENT OF CLAIMS:
All benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to their beneficiary as described in the Designation or Change of Beneficiary provision of the Policy.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to $1,000 to a relative by blood or marriage whom We believe is equitably entitled. This good faith payment satisfies Our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Covered Person's death may, at Our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Covered Person.

When payments of benefits are made to the Covered Person directly for medical care or services rendered by a health care provider, the health care provider shall be notified of such payment. If the Covered Person provides Us with written direction that all or a portion of any indemnities or benefits provided by the Policy be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then We shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the provider, who may not bill or collect from the Covered Person any amount above that payment, other than the Deductible, Coinsurance, Copayment or other charges for equipment or services requested by the Covered Person that are noncovered benefits. Any dispute between a provider and the Covered Person arising under these provisions regarding assignment of benefits and billing may be resolved by the Commissioner of Insurance.

DESIGNATION OR CHANGE OF BENEFICIARY:
Each Covered Person may designate a beneficiary to whom loss of life benefits are payable.

A Covered Person may change their beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

A Dependent's beneficiary is the Insured Person. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Insured Person's estate.

PHYSICAL EXAMINATION:
We have the right to have a Medical Professional of Our choice examine the Covered Person as often as is reasonably necessary. This provision applies when a claim is pending or while benefits are being paid. We will pay the cost of the examination.

RECOVERY OF OVERPAYMENT:
If benefits are overpaid or paid in error, We have the right to recover the amount overpaid or paid in error by any lawful method, which may include the following:
1) A request for lump sum payment of the amount overpaid or paid in error; or
2) Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error.

SUBROGATION:

If We have made a payment for a loss under the Policy, and a Covered Person has a right to recover damages from a third party responsible for the loss, We have the right to pursue a refund or recovery even if such Covered Person does not do so. This is called subrogation. When We exercise our right of subrogation, We will be assigned the rights and remedies the Covered Person had relating to the loss.

This Subrogation provision shall not apply until the Covered Person is first made whole for his or her loss.

A Covered Person must help Us preserve Our right of subrogation against those responsible for the loss. This may involve signing papers and taking any other steps We may reasonably require. A Covered Person shall help Us exercise Our rights in any reasonable way that We may request. A Covered Person shall not do anything after the loss to prejudice Our rights.

If We have paid benefits to a Covered Person for Injuries received in a Covered Accident, and in Our opinion a third party may be liable, We will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer His rights to Us. We will exercise such rights on His behalf. He further agrees to furnish Us with all relevant information and documents.

LEGAL ACTIONS:

All Policy terms will be interpreted under the laws of the state in which the Policy was issued. No legal action may be brought to recover on the Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:
The Policy, the Master Application of the Policyholder (a copy of which is attached to the Policy), endorsements, riders, and attached papers, including this Certificate, constitute the entire contract between the parties. If an Enrollment Form for a Covered Person is required, We may also make it a part of this contract.

No change in the Policy will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

REPRESENTATIONS AND NOT WARRANTIES:
All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause Us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of their death or incapacity, their beneficiary or representative. After two years from the Covered Person's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

WORKERS' COMPENSATION INSURANCE:
The Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

POLICY TERMINATION:
We may terminate coverage on or after any premium due date. The Policyholder may terminate its coverage on any premium due date. If either party terminates, written notice must be given to the other party at least 60 days prior to such premium due date.

CONFORMITY WITH STATE STATUTES:
Any provision of the Policy in conflict on its Effective Date with the statutes of the jurisdiction in which the Insured Person resides on such date is hereby amended to conform to the minimum requirements of such statutes.

CLERICAL ERROR:
Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

ASSIGNMENT:
This coverage may not be assigned. However, benefit payments may be assigned at the time of claim. Any payment made by the Company in good faith will end Our liability to the extent of the payment.

No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

INSOLVENCY:
The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in the Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under the Policy.

NON-PARTICIPATING:
The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

WAIVER:
Failure of the Company to strictly enforce its rights under the Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

NEW ENTRANTS:
To the group originally insured may be added from time to time eligible new persons or Dependents, as the case may be, in accordance with the terms of the Policy.

MISSTATEMENT OF AGE:
If premiums and/or benefits for the Covered Person are based on age and the Covered Person’s age has been misstated, there will be a fair adjustment of benefits based on the Covered Person’s true age. The Company may require satisfactory proof of age before paying any claim.

CRITICAL ILLNESS BENEFIT RIDER

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This Rider is made a part of the Group Policy and any Certificate of Insurance to which it is attached. The provisions of this Rider are effective on the Covered Person's Certificate Effective Date and will expire concurrently with the Group Policy and Certificate, unless otherwise terminated. This Rider is subject to all of the terms, limitations and exclusions of the Group Policy and Certificate, except as they are changed by this Rider.

The Group Policy and Certificate of Insurance to which this Rider is attached is hereby amended to include the following benefit:

CRITICAL ILLNESS BENEFIT

We will pay the percentage of the Critical Illness Benefit Amount, shown in the Rider Schedule of Benefits, if the Covered Person is First Diagnosed with a Critical Illness Covered Condition listed in the Rider Schedule of Benefits after their effective date of coverage under this Rider and after the Critical Illness Benefit Waiting Period shown in the Rider Schedule of Benefits.

The Covered Person must be covered continuously under the Policy and this Rider before the Critical Illness Benefit Amount may be payable and the Critical Illness Covered Condition must first occur after the Critical Illness Benefit Waiting Period. If the Covered Person's condition is First Diagnosed during the Critical Illness Benefit Waiting Period, no benefits will be payable, this Rider will terminate for such Covered Person, and We will refund to the Covered Person all premiums paid for this Rider without interest.

The Critical Illness Benefit is only paid once per Covered Person's lifetime. After the payment is made to the Covered Person, this Critical Illness Benefit will terminate for such Covered Person.

The Critical Illness Benefit Amount is not payable for conditions other than the Critical Illness Covered Conditions shown in the Rider Schedule of Benefits.

RIDER SCHEDULE OF BENEFITS

CRITICAL ILLNESS BENEFIT AMOUNT: $15,000 per Covered Person
for All Classes

CRITICAL ILLNESS BENEFIT WAITING PERIOD: 30 days per Covered Person
for All Classes

CRITICAL ILLNESS COVERED CONDITIONS	PERCENTAGE OF CRITICAL ILLNESS BENEFIT AMOUNT
Cardiac:	
Heart Attack (Myocardial Infarction)	100%
Sudden Cardiac Arrest	100%
Coronary Artery Disease requiring Coronary Artery Bypass	25%
Coronary Artery Disease requiring Angioplasty	100%

Cerebral Vascular Disease:	
Stroke	100%
Ruptured Brain Aneurysm	100%
Transient Ischemic Attack	100%
Other Specified Illness:	
Bone Marrow/Stem Cell Transplant	100%
Coma	100%
End Stage Renal (Kidney) Failure	100%
Major Organ Failure requiring Transplant	100%
Occupational Infectious Hepatitis B, C or D	100%
Occupational Infectious HIV	100%
Benign Brain Tumor	100%
Permanent Paralysis:	
Quadriplegia	100%
Paraplegia	100%
Hemiplegia/Diplegia	100%
Other Accident:	
Severe Burns Covered Dependent Children are not covered for Severe Burns.	100%
Cancer:	
Invasive	100%
Non-Invasive	25%
Skin Cancer	$100 per lifetime

DEFINITIONS

Benign Brain Tumor means a brain tumor that is not a malignant, recurrent, or progressive tumor as confirmed by the examination of tissue (biopsy or surgical excision), MRI, magnetic resonance spectroscopy (MRS), or CT. The brain tumor must result in neurological deficit(s), including but not limited, vision or hearing impairments; seizures; facial paralysis; numb extremities; changes in concentration, memory, or speech; or balance disruption.

For purposes of this Rider, the following do not meet the definition of Benign Brain Tumor:

- tumors of the skull;
- angiomas or aneurysms
- pituitary adenomas; and
- germinomas.

We will not pay the benefit for Benign Brain Tumor if the Covered Person is Diagnosed prior to their effective date of coverage under this Rider with any of the following conditions:

- neurofibromatosis I;
- neurofibromatosis II;
- von Hippel-Lindau;
- tuberous sclerosis;
- Li-Fraumani syndrome;
- cowden disease; and
- turcot syndrome.

Benign Brain Tumor Date of Diagnosis is the date of the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Bone Marrow/Stem Cell Transplant means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells due to an aplastic anemia, congenital neutropenia, severe immunodeficiency syndromes, sickle cell

anemia, thalassemia, Fanconi anemia, leukemia, lymphoma, or multiple myeloma.

Bone Marrow/Stem Cell Transplant Date of Diagnosis is determined by the date of date of onset for medical condition the transplant is associated with, which must be a Covered Loss.

Coma means a continuous state of profound unconsciousness requiring intubation for respiratory assistance as the result of a severe traumatic brain injury lasting for a period of 7 or more consecutive days, characterized by the absence of:

- eye opening;
- verbal response; and
- motor response.

For purposes of this Rider, the following do not meet the definition of Coma:

- coma due to stroke; and
- any medically induced coma.

Coma Date of Diagnosis is the date a Medical Professional confirms a Coma.

Coronary Artery Disease means a narrowing or blockage of one or more coronary arteries resulting from plaque buildup.

- Coronary Artery Bypass means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, performed by a Medical Professional who is a board-certified cardiothoracic surgeon.
- Coronary Artery Angioplasty means a procedure used to open clogged heart arteries by utilizing a balloon catheter inserted in a blocked blood vessel to help widen it, performed by a Medical Professional who is a board-certified cardiothoracic surgeon.

Coronary Artery Disease Date of Diagnosis is the date a cardiologist recommends a covered person undergo a surgical procedure of either a coronary artery bypass graft or valve replacement.

Date of Diagnosis means the date a Medical Professional confirms, or a test proves, that a Critical Illness Covered Condition exists. Date of Diagnosis requirements vary by Covered Condition, and are specified in this Definitions section.

Diagnosis or **Diagnosed** means a written diagnosis by a Medical Professional of the Covered Person's Critical Illness Covered Condition.

Diplegia means complete and irreversible loss of all motion and all practical use of both arms or both legs as determined by a Medical Professional .

End Stage Renal (Kidney) Failure means chronic irreversible failure of the function of both kidneys such that the Covered Person must undergo at least weekly hemodialysis or peritoneal dialysis.

End Stage Renal (Kidney) Failure Date of Diagnosis means the date that a Medical Professional recommends regular hemodialysis or peritoneal dialysis to sustain life; the Covered Person has a kidney transplant performed; or the Covered Person is placed on the UNOS (United Network for Organ Sharing) list for a kidney transplant.

First Diagnosis means the first time a Medical Professional Diagnoses a Covered Person as having a Critical Illness Covered Condition, which has been clinically or pathologically Diagnosed by a Medical Professional after the Critical Illness Benefit Waiting Period and while their coverage under this Rider is in force.

Heart Attack (Myocardial Infarction) means the ischemic death of a portion of heart muscle (myocardium) as a result of obstruction of one or more of the coronary arteries. A positive Diagnosis of myocardial infarction must occur and must be supported by three or more of the following:

- chest pain;
- electrocardiographic (EKG) changes indicative of myocardial infarction; in the case of myocardial infarction associated with percutaneous coronary intervention (balloon angioplasty, stent implantation, and related

procedures to increase the flow of blood through the coronary arteries), evolving ST elevations or new Q wave changes must be documented and included as one of the criteria in establishing a diagnosis;
- elevation of biochemical markers of myocardial necrosis; and
- confirmatory imaging studies.

In the event of death, an autopsy, medical examiner's confirmation, or death certificate identifying Heart Attack (Myocardial Infarction) as the cause of death will be accepted.

The following are not to be construed as a Heart Attack (Myocardial Infarction) for purposes of this Rider:
- an established (old) heart attack;
- angina;
- atherosclerotic heart disease;
- cardiac arrest (including arrhythmias);
- congestive heart failure;
- coronary artery disease; and
- any other disease, injury, or dysfunction of the cardiovascular system.

Heart Attack (Myocardial Infarction) Date of Diagnosis is the date the ischemic death of a portion of the heart muscle (myocardium) occurred based on the criteria listed under the Heart Attack (Myocardial Infarction) definition.

Hemiplegia means complete and irreversible loss of all motion and all practical use of one arm and one leg on the same side of the body as determined by a Medical Professional .

Invasive Cancer means a disease that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells and must be Diagnosed in one of two ways:
1. Clinical Diagnosis: A Clinical Diagnosis of Invasive Cancer is based on the study of symptoms. We will pay benefits for a Clinical Diagnosis only if:
    a. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening;
    b. there is medical evidence to support the Diagnosis; and
    c. a Medical Professional is treating the Covered Person for Invasive Cancer.
2. Pathological Diagnosis: A Pathological Diagnosis of Invasive Cancer made by a pathologist is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of malignancy Diagnosis must be in accordance with the standards established by the American Board of Pathology. A Pathological Diagnosis of Invasive Cancer can be made before or after death.

The following are not to be construed as Invasive Cancer for purposes of this Rider:
- pre-malignant conditions or conditions with malignant potential;
- cancer that has not become invasive, typically classified as stage 0 or in situ;
- cancer on the surface of the body (skin) that may be:
    - melanomas that are in situ, stage 0, stage 1, or stage 2;
    - basal cell carcinoma; or
    - squamous cell carcinoma of the skin; and
- a flare-up, spread or metastasis of a cancer (invasive) that the Covered Person was First Diagnosed with before their effective date of coverage under this Rider.

Invasive Cancer Date of Diagnosis means the date the tissue specimen, blood samples or titer(s) are taken upon which the Diagnosis of Invasive Cancer or Non-Invasive Cancer is based.

Major Organ Failure Requiring Transplant means failure of the heart, kidney, liver, both lungs, or pancreas resulting in the Covered Person being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

Major Organ Failure Requiring Transplant Date of Diagnosis is the date that the Covered Person is placed on the UNOS list for transplantation.

Non-Invasive Cancer means a malignant tumor which is typically classified as stage 0 or in situ, that has not yet become invasive but is confined to the site of origin without having invaded neighboring tissue.

For purposes of this Rider, the following do not meet the definition of Non-Invasive Cancer:

- pre-malignant conditions or conditions with malignant potential; and
- cancer on the surface of the body (skin) that may be:
    - melanomas that are in situ, stage 0, or stage 1;
    - basal cell carcinoma; or
    - squamous cell carcinoma of the skin.

Non-Invasive Cancer Date of Diagnosis means the date the tissue specimen, blood samples or titer(s) are taken upon which the Diagnosis of Invasive Cancer or Non-Invasive Cancer is based.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D means Diagnosis of Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C or D resulting from exposure to HIV-contaminated or Hepatitis B, C or D contaminated fluids as the result of a Covered Accident during the normal course of performing an occupation for which remuneration is earned. We will pay this benefit if:

- within five days of the Covered Accident, it is reported and recorded by the appropriate person according to the legislation, regulations, standards or guidelines that apply to the Covered Person's occupation or profession;
- the Covered Accident is investigated and a written investigation report is provided to Us by the Covered Person's employer;
- a confirmatory antibody HIV or Hepatitis B, C or D test is taken within five days of the Covered Accident and HIV or Hepatitis B, C or D is not present;
- all HIV or Hepatitis B, C or D tests are performed by a state certified and licensed laboratory; and
- a follow-up confirmatory antibody HIV or Hepatitis B, C or D test is taken between 90 days and 180 days after the Covered Accident, and the result is positive.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D excludes:

- HIV or Hepatitis B, C or D infection as the result of IV drug use;
- HIV or Hepatitis B, C or D infection as the result of sexual transmission; and
- HIV or Hepatitis B, C or D infection determined not to have been the result of a Covered Accident.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D Date of Diagnosis is the date of a positive antibody test for HIV or Hepatitis B, C or D subsequent to a prior negative test for the same condition with a lapse of between 90 and 180 days between the two tests.

Paraplegia means complete and irreversible loss of all motion and all practical use of both legs, as determined by a Medical Professional .

Pathologist means a Medical Professional who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Permanent Paralysis means a definite Diagnosis of Quadriplegia, Paraplegia, Diplegia or Hemiplegia. The Diagnosis of Paralysis must be made by a Medical Professional . The spinal cord Injury causing the Paralysis must occur on or after the Covered Person's effective date of coverage and while this Rider is in force for benefits to be payable.

Permanent Paralysis Due to a Covered Accident Date of Diagnosis The date a Medical Professional diagnoses the paralysis or severed spinal cord.

Quadriplegia means complete and irreversible loss of all motion and all practical use of both arms and legs, as determined by a Medical Professional .

Ruptured Brain Aneurysm means an abnormal bulge or ballooning of a blood vessel in the brain that has ruptured causing bleeding into the brain, as confirmed by CT, CT angiography (CTA), cerebrospinal fluid test, MRI, or MRI and angiography MRA.

Ruptured Brain Aneurysm Date of Diagnosis is the date a test or series of tests, including but not limited to computerized tomography (CT); cerebrospinal fluid test; magnetic resonance imaging (MRI); or cerebral angiogram, confirms the ruptured aneurysm.

Severe Burns means a Diagnosis, by a Medical Professional board-certified as a Plastic Surgeon, that the Covered Person has sustained third degree burns resulting from a Covered Accident covering at least 20% of the total body surface area (TBSA) of the Covered Person's body.

Severe Burn Date of Diagnosis is the date, following the Covered Person's effective date of coverage under this Rider, that the Covered Person was involved in a Covered Accident resulting in a positive Diagnosis by a Medical Professional of a Severe Burn.

Skin Cancer means cancer on the surface of the body (skin) that may be:
- melanomas that are in situ, stage 0, or stage 1;
- basal cell carcinoma; or
- squamous cell carcinoma of the skin.

Skin Cancer Date of Diagnosis means the date the tissue specimen is taken on which the Diagnosis of Skin Cancer is based.

Stroke means the sudden death of brain cells due to lack of oxygen, caused by blockage of blood flow or rupture of an artery to the brain.

The following are not to be construed as a Stroke for purposes of this Rider:
- transient ischemic attack;
- brain injury related to trauma or infection;
- brain injury associated with hypoxia/anoxia or hypotension;
- vascular disease affecting the eye or optic nerve; and
- ischemic disorders of the vestibular system.

If a Stroke results in death, an autopsy confirmation verifying Stroke as the cause of death will be accepted.

Stroke Date of Diagnosis is the date a Stroke occurs, and the Diagnosis must be supported by:
- evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the stroke, including but not limited to: impaired motor function, altered sensation, vision loss, difficulty swallowing, or cognitive impairment; and
- confirmatory neuroimaging studies consistent with the diagnosis of a new stroke.

Sudden Cardiac Arrest means the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, Cardiomyopathy, or Hypertension. Sudden Cardiac Arrest does not mean a Heart Attack (Myocardial Infarction).

Sudden Cardiac Arrest Date of Diagnosis is the date the pumping action of the heart fails based on the Sudden Cardiac Arrest definition.

Transient Ischemic Attack (TIA) means a brief episode of neurologic dysfunction, caused by local brain or retinal ischemia, with clinical symptoms typically lasting less than one hour, during which dizziness, blurred vision, numbness on one side of the body and other symptoms of a stroke may occur. Diagnosis of the TIA must meet all the following requirements:
- The Covered Person must have sought medical intervention for a TIA within 24 hours of the onset of the TIA;
- There is a new ischemic event with no cerebral infarction or tissue damage and reversible impairment as confirmed by Clinical Diagnosis;
- Clinical Diagnosis includes documentation of recommended treatment for Stroke prevention; and,
- The impairment must be focal and confined to an area of the brain perfused by a specific artery.

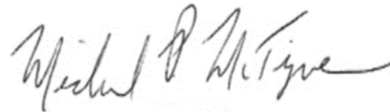
Transient Ischemic Attack (TIA) Date of Diagnosis is the date of transient ischemic change is confirmed by a Medical Professional 's physical and neurological exam and other possible causes of the Covered Person's symptoms are ruled out by testing, including but not limited to: Angiography; Arteriography; Carotid ultrasonography or ultrasound; Computerized tomography (CT) or computerized tomography angiography (CTA); Echocardiography; or Magnetic resonance imaging (MRI).

Any benefits provided under this Rider will not duplicate any other benefits payable under the Policy/Certificate or any coverages attached to the Policy/Certificate.

Except for the above, this Rider does not vary, alter, waive, or extend any of the terms of the Policy/Certificate to which it is attached. Benefit payment is subject to the definitions, limitations, exclusions, and other provisions of the Policy/Certificate.

Coverage under this Rider will end for each Covered Person when coverage ends under the Certificate to which it is attached.

Signed for **United States Fire Insurance Company** by:



Marc J. Adee
Chairman and CEO

Michael P. McTigue
Secretary

Mississippi Guaranty Notice

NOTICE OF PROTECTION PROVIDED BY MISSISSIPPI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Mississippi Life and Health Insurance Guaranty Association (the "Association") and the protection it provides for policyholders. This safety net was created by Mississippi law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurer becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Mississippi law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

Life Insurance
- $300,000 in death benefits
- $100,000 in net cash surrender and net cash withdrawal values

Health Insurance
- $500,000 for health benefit plans (see definition below)
- $300,000 in disability income insurance benefits
- $100,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in Miss. Code Ann. § 83-23-209 and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Mississippi law.
Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates

To learn more about the above protections, limitations and exclusions, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mslifega.org, or contact:

Mississippi Life and Health Insurance
Guaranty Association
P.O. Box 4562
Jackson, MS 39296 or
330 North Mart Plaza
Jackson, MS 39206-5327
601-981-0755
www.mslifega,org

Mississippi Insurance Department
Woolfolk State Office Building
501 N. West Street, Suite 1001
Jackson, MS 39201
601-359-3569
www.mid.ms.gov

To file a complaint or seek information about the financial condition of an insurer, contact the Mississippi Insurance Department.

Your insurer is required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance.

FRAUD WARNING STATEMENT

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KANSAS: A "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit

pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

KENTUCKY:
Application: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
Claim Form: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY:
Application: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
Claim Form: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON:

IMPORTANT NOTE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefit.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NEW YORK*: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee Signature ___________________________ Date _________________________

*The fraud warning in NY must appear above the signature line.

When used throughout this document “Company”, “Our”, “We”, or “Us” means

United States Fire Insurance Company

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we’ve made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

A **“Grievance”** is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

An **“Adverse Determination”** is a determination by the Company or its designated utilization review organization that (i) a service, treatment, drug, or device, is experimental, investigational, specifically limited or excluded by your coverage; or (ii) a facility admission, the availability of care, continued stay or other health care services proposed or furnished have been reviewed and, based upon the information provided, does not meet the contractual requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore, the benefit coverage is denied, reduced or terminated in whole or in part.

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60 days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don’t have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30 days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

First Level Review

Within 3 working business days after receiving the Grievance, we must acknowledge the Grievance and provide you, your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.

Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20 days after receiving the Grievance. The written decision must include:

Grievance

(1) The name(s), title(s) and professional qualifications of any person(s) participating in the First Level Review process.
(2) A statement of the reviewer's understanding of the Grievance.
(3) The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.
(4) A reference to the evidence or documentation used as the basis for the decision.
(5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
(6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

The Second Level Review process is available if you are not satisfied with the outcome of the Frist Level Review for an Adverse Determination. Within 10 business days after receiving a request for a Second Level Review, we will advise you of the following:

(1) The name, address, and telephone number of a person designated to coordinate the Grievance Review for the Company.
(2) A statement of your rights, including the right to:
- Attend the Second Level Review.
- Present his/her case to the review panel.
- Submit supporting materials before and at the review meeting.
- Ask questions of any member of the review panel.
- Be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney.
- Request and receive from us free of change, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination.

We must convene a review panel and hold a review meeting within 45 days after receiving a request for a Second Level Review. We will notify you in writing of the meeting date at least 15 days prior to the date. The review meeting will be held during regular business hours at a location reasonably accessible to you. In cases where a face-to-face meeting is not practical for geographical reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

If you choose to be represented by an attorney, we may also be represented by an attorney. If we choose to have an attorney present to represent our interests, we will notify you at least 15 working days in advance of the review that an attorney will be present and that you may wish to obtain legal representation of your own.

The panel must be comprised of persons who:

(1) Were not previously involved in any matter giving rise to the Second Level Review;
(2) Are not employees of the Company or Utilization Review Organization; and
(3) Do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, we may use one of our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.

We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:

(1) The name(s), title(s) and qualifying credentials of the members of the review panel.
(2) A statement of the review panel's understanding of the nature of the Grievance and all pertinent facts.
(3) The review panel's recommendation to the Company and the rationale behind the recommendation.
(4) A description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation.

Grievance

(5) In the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination.
(6) The rationale for the Company's decision if it differs from the review panel's recommendation.
(7) A statement that the decision is the Company's final determination in the matter.
(8) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED REVIEW

Your are eligible for an expedited review when the time frames for an Informal, formal First Level Review or Second Level Review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24 hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72 hours after the review has commenced. Written communication of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level Reviews.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.

FACTS

WHAT DOES CRUM & FORSTER DO WITH YOUR PERSONAL INFORMATION?

Rev. August 1, 2025

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: - Social Security number and income - credit scores and credit-based insurance scores - insurance claim history and employment information
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Crum & Forster chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Crum & Forster share?	Can you limit this sharing?
For our everyday business purposes— such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes— to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes— information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes— information about your creditworthiness	No	We don't share
For our affiliates to market to you	Yes	Yes
For nonaffiliates to market to you	No	We don't share

To limit our sharing

- ☐ Call 844.254.5754
- ☐ Email us at: CFChiefLegalOfficer@cfins.com

Please note: If you are a *new* customer, we can begin sharing your information 30 days from the date we sent this notice. When you are no longer our customer, we continue to share your information as described in this notice.

However, you can contact us at any time to limit our sharing.

Questions

Call 844.254.5754 or email us at: CFChiefLegalOfficer@cfins.com unless you provide a separate FCRA opt out form.

Who are we	
Who is providing this notice?	Crum & Forster and its affiliates.

What we do	
How does Crum & Forster protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with applicable federal and state law.These measures include computer safeguards and secured filesand buildings.
How does Crum & Forster collect my personal information?	We collect your personal information, for example, when you ■ apply for insurance or pay insurance premiums ■ file an insurance claim or give us your contact information ■ provide employment information We also collect your personal information from others, such as credit bureaus, affiliates or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only ■ sharing for affiliates' everyday business purposes—information about your creditworthiness ■ affiliates from using your information to market to you ■ sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ■ *Our affiliates include: United States Fire Insurance Company, The North River Insurance Company, Crum & Forster Indemnity Company, Seneca Insurance Company, Inc., Travel Insured International, Inc., Monitor Life Insurance Company of New York, MTAW Insurance Company, Bail USA, Inc. and any other company within the Crum & Forster group of companies.*
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ■ *Crum & Forster does not share with nonaffiliates so they can market to you.*
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. ■ *Crum & Forster doesn't jointly market.*

Other important information

For Insurance Customers in AZ, CT, GA, IL, ME, MA, MN, MT, NV, NJ, NC, OH, OR and VA only. The term "Information" in this section means customer information obtained in an insurance transaction. We may give your Information to state insurance officials, law enforcement, group policy holders about claims experience or auditors as the law allows or requires. We may give your Information to insurance support companies that may keep it or give it to others. We may share medical information, so we can learn if you qualify for coverage, process claims or prevent fraud or if you say we can.

To see your Information, submit a request via email to CFChiefLegalOfficer@cfins.com. You must state your full name, address, the insurance company, policy number (if relevant) and the Information you want. We will tell you what Information we have. You may see and copy the Information (unless privileged) at our office or ask that we mail you a copy for a fee. If you think any Information is wrong, you must write us. We will let you know what actions we take. If you do not agree with our actions, you may send us a statement.

For California Residents only. We will not share information we collect about you with nonaffiliated third parties, except as permitted by California law. We will limit sharing among our affiliates to the extent required by California law. We do not share information about creditworthiness. For further information visit our website.

You have the right to submit a written request to access, correct, amend, or delete certain personal information we collect about you. To submit a request please write your request and send it to the following privacyinformation@cfins.com. You have the right to receive a response to your request within 30 business days of the date of the submission of your request to access, correct, amend, or delete your personal information. If we refuse your request, you have the right to file a statement regarding what you believe to be accurate and fair information and why you disagree with our response. For more information see C&F's Model 670 Notice at https://www.cfins.com/onlineprivacypolicy/glba/cfmodel670/

For Massachusetts Residents only. You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate or terminate your coverage.

For Nevada Residents only. We are providing you this notice under state law. Nevada law requires we provide the following contact information: Bureau of Consumer Protection, Office of the Nevada Attorney General, 555 E. Washington St., Suite 3900, Las Vegas, NV 89101; Phone number: 702.486.3132; email: aginfo@ag.nv.gov; Crum & Forster: Legal Department, P.O. Box 1973, 305 Madison Avenue, Morristown, NJ 07962, 844.254.5754, CFChiefLegalOfficer@cfins.com.

For North Dakota Residents only. We will not share information we collect about you with nonaffiliated third parties, except as permitted by North Dakota law. We will limit sharing among our affiliates to the extent required by North Dakota law. For further information visit our website.

For Vermont Residents only. Under Vermont law, we will not share information we collect about Vermont residents with companies outside of our affiliates, unless the law allows. We will not disclose information about your creditworthiness to our affiliates and will not disclose your personal information, financial information, credit report, or health information to nonaffiliated third parties to market to you, other than as permitted by Vermont law, unless you authorize us to make those disclosures. Additional information concerning our privacy policies can be found on our website.